Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $1,076.40 for date of service 11/13/01.

   b. The request was received on 02/20/01.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 02/20/02
   b. HCFA-1500
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 04/05/02
   b. HCFA(s)-1500
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. The Commission's case file does not contain a Notice of Request for Medical Dispute Resolution, based on the additional requestor's information being received on 04/03/02 and the carrier's 14 day information being received on 04/09/02, therefore, all information in the case file will be considered timely.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated 02/20/02, "Our contention is: The treatment received was medically necessary, pre-authorization was received, and billing was done in accordance with TWCC fee guideline."

2. Respondent: The respondent representative stated in correspondence dated 04/05/02, "**In the Texas Workers' Compensation Commission's Medical Fee Guideline…, under General Instructions, Section VI. Reimbursement, it states 'HCPs shall bill their usual and customary charges'. These are the same charges that the health care provider charges 'for similar treatment of an injured individual of an equivalent standard of living…' (Labor Code, Section 413.011(b)….the insurance carrier shall pay the lesser of the charged amount, the MAR…or, when there is no MAR to pay at a fair and reasonable rate.**"

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 11/13/01.

2. The carrier's EOB(s) have the denial codes:
"F – FEE GUIDELINE MAR REDUCTION NO TIME STATING PT WAS IN RECOVERY ROOM FOR 8 HOURS, ONE UNIT WAS BILLED.";
M – NO MAR SET BY TWCC-REDUCED TO FAIR AND REASONABLE SUPPLY IV NEEDLE";
"G – UNBUNDLING."

3. No other EOB(s) or medical audits were noted, therefore, the Medical Review Division's decision is rendered based on the denial codes submitted prior to the date of this dispute being filed.

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Codes	MAR$	REFERENCE	RATIONALE:
11/13/01 11/13/01 11/13/01	99499-RR 99070-AS A4649	$800.00 $325.00 $106.00	$100.00 $54.60 $0.00	F M G,F,M	DOP DOP DOP	Rule 133.1 (a) (E) (8) (B); Rule 413.011 (b); MFG SGR (V); MFG GI (III) (VI); CPT descriptors	The MFG GI (III) states, "(DOP) in the …(MAR) column indicates that the value of this service shall be determined by written documentation attached to or included in the bill." This places the burden on the provider to show what is fair and reasonable reimbursement. MFG GI (VI) indicates, "…(DOP) shall be reimbursed at the fair and reasonable rate." Rule 133.1 (a) (E) (8) states, "Fair and reasonable reimbursement - Reimbursement that meets the standards set out in §413.011 of the Texas Labor Code, and the lesser of a health care provider's usual and customary charge, or the determination of a payment amount for medical treatment(s) and/or service(s) for which the Commission has established no maximum allowable

							reimbursement amount…" The HCFA(s) indicate the services were performed in a doctor's office. MFG SGR (V) (B) list the only reimbursements allowed for facility charges in a doctor's office. Code A4649 is not a billable code per SGR (V) (B). The provider did not meet the burden of proof of demonstrating that they were not reimbursed a fair and reasonable rate of reimbursement. The provider did not document that reimbursement requested is fair and reasonable. **No** reimbursement is recommended.
Totals		$1,231.00	$154.60				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 11th day of July 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.